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Good morning, Mr. Chairman. I am Donald Young, M.D., Executive Director of the Prospective Payment Assessment Commission (ProPAC). I am pleased to be here to discuss Medicare's policies for home health care agencies. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, Mr. Chairman, payments to home health agencies are one of the fastest growing components of the Medicare program. Between 1990 and 1996, total home health payments increased five-fold, from $3.5 billion to $17.7 billion (see Chart 1). Home health spending has grown from 6 percent of total Part A spending in 1990 to 14 percent in 1995. While spending has slowed somewhat in the past two years, the Congressional Budget Office projects that payments to home health agencies will continue to rise faster than overall Medicare spending between now and 2002.

The dramatic rise in home health spending is due to increases in both the number of beneficiaries receiving services and the number of visits they receive. While Medicare has modified its policies over the years to slow the growth in payments per visit, its ability to control the number of visits provided has remained elusive. As I will describe in a moment, this is due in part to deficiencies in current coverage and payment policies.

In the Commission's most recent *Report and Recommendations to the Congress*, which we released on Monday, ProPAC makes a number of recommendations to improve Medicare's payment policies for home health care and control spending increases. This morning, I would like to discuss those recommendations. But first, I would like to briefly summarize the home health care benefit and reasons associated with its growth.

The Home Health Benefit

Home health care may be covered under Medicare Part A or Part B. Beneficiaries enrolled in both Parts A and B--about 95 percent of the Medicare population--receive home health care under Part A. Beneficiaries who are not eligible for Part A but are enrolled in Part B receive home health care under Part B.

To qualify for the home health benefit under either Part A or Part B, a beneficiary must be homebound and under the care of a physician who prescribes intermittent skilled nursing services, or physical or speech therapy. The physician must review and re-sign the care plan at least every 62 days for a beneficiary to continue receiving services. Once authorized, beneficiaries may also receive home health aide services, occupational therapy, or medical social services. Beneficiaries pay no coinsurance or deductibles for home health visits, and there are no program limits on the number of visits they may receive.

Medicare beneficiaries receive home health services from a Medicare-certified agency. The agency may be part of a hospital or other facility, or may be an independent free-standing organization. Medicare pays these agencies the lower of their costs or a limit. The limits are based on 112 percent of the average cost per visit for free-standing agencies for each of the six visit types, computed separately for urban and rural areas (see Chart 2). Medicare does not specify the duration of a visit; therefore, the limits reflect varying visit lengths across and within individual agencies.

Although the limits are computed at the service level, they are applied to aggregate agency costs. The result is an aggregate payment limit for each agency that equals the limit for each type of service multiplied by the corresponding number of visits.

The Growth in Home Health Payments

As I mentioned earlier, the growth in home health spending is mainly a result of increases in the number of visits provided rather than increases in payments per visit. This utilization growth, in turn, has been associated with changes in Medicare's home health policies.

For many years, home health expenditures accounted for a small share of total Part A spending, reaching about 2 percent in 1980. Before 1980, beneficiaries could receive home health care under Part A but only if they had a three-day prior hospitalization. They also were limited to 100 visits. If the beneficiary required more than 100 visits and was eligible for Part B, they could receive an additional 100 visits, so long as they met the applicable deductible. Beneficiaries who did not have a prior hospitalization or were not eligible for Part A benefits could receive up to 100 visits under Part B, again so long as they paid the deductible.

The Omnibus Budget Reconciliation Act of 1980 eliminated the hospital stay requirement under Part A, the deductible requirement under Part B, and the 100 visit limit under both Parts A and B. This resulted in a jump in utilization. In response, the Health Care Financing Administration (HCFA) used administrative means to tighten the coverage criteria. Over the next several years, increases in home health payments were relatively small, and the number of people served as well as the number of visits per person remained relatively stable. HCFA's actions, however, spurred a legal challenge in 1988. The court ruled that HCFA's actions were contrary to legislative intent under the Medicare law. In response, HCFA loosened its coverage requirements.

After this decision, the number of beneficiaries receiving home health care and the number of visits they received spiralled. Between 1989 and 1996, the number of beneficiaries receiving home health more than doubled, from about 1.6 million to 3.7

million. The number of visits the average user received per year nearly tripled over this period, from 26 to 76 (see Chart 3).

Cost-based reimbursement combined with few constraints on utilization have attracted new entrants into the home health care market, which also has contributed to utilization growth. Between 1990 and 1996, the number of agencies grew by 71 percent to reach 9,886 (see Chart 4). The supply of free-standing and hospital-based facilities rose at about the same rate.

The growing use of home health services has been associated with changes in the mix of services provided. Skilled nursing and home health aides represent the bulk of home health visits. Home health aides furnish personal care services (such as bathing, dressing, and grooming), simple wound dressing changes, and assistance with medications. In 1988, skilled nursing services represented the larger share of visits provided, 51 percent of the total compared to 34 percent for home health aides. In 1994, however, home health aide visits were more prevalent, accounting for 48 percent of visits compared to 42 percent for skilled nursing services (see Chart 5).

The bulk of home health visits are not associated with a hospitalization. A recent ProPAC analysis revealed that while 60 percent of home health episodes--defined as a group of visits preceded and followed by a 60 day period without visits--were preceded by a hospital stay, 85 percent of home health visits in a given month did not follow a hospital stay within 30 days of the visit and about 50 percent of visits were received by beneficiaries who did not have a hospitalization within the previous year.

Beneficiaries' use of home health care reveals two distinct patterns. ProPAC analysis of fiscal year 1994 data shows that half of beneficiaries who received home health care received fewer than 30 visits. These visits were generally provided over a short period, and the majority of them were for skilled nursing services. By contrast, 12 percent of home health users had 150 or more visits (see Chart 6). These users

tended to receive home health care over long periods of time, sometimes a year or more, and to receive more home health aide visits.

This small group of beneficiaries receiving large amounts of visits account for the bulk of home health use. In 1994, they accounted for slightly more than half of all visits and two-thirds of all home health aide visits. These individuals are likely to be older or disabled.

ProPAC's Home Health Recommendations

Controlling spending for home health care is especially challenging because of the need to control service usage. In turn, controlling utilization is complicated because of broad coverage guidelines and wide variations in treatment protocols. To help gain insight into long-term use patterns, the Commission recommends that the Secretary analyze the factors associated with long-term use to determine whether additional policy changes may be desirable.

In addition to this recommendation, ProPAC believes a number of changes should be made to improve the home health benefit and control spending increases. These focus on more clearly defining the benefit, implementing changes to the payment system, and having beneficiaries share in the financial responsibility for home health services. I would like to summarize each of these recommendations.

Defining the Home Health Care Benefit

One of the difficulties in constraining home health spending is the existence of broad coverage guidelines that allow for prolonged service use by an increasing number of beneficiaries. Beneficiaries qualify for home health services if they are homebound and under the care of a physician who prescribes intermittent skilled nursing care or physical or speech therapy. The homebound requirement is not very restrictive and is difficult to enforce. The physician certification requirement is a weak

restraint at best, partly because there are no specific criteria to guide physicians' determinations of the need for skilled services.

Currently, the Medicare program is paying for what appear to be two different types of benefits. One covers care that is of short duration and is heavily weighted to skilled services. The other covers longer-term care that is weighted towards home health aide services.

The Commission believes that the Medicare program has a responsibility to ensure that the services it pays for are reasonable, necessary, and medically appropriate. The lack of a clearly defined benefit compromises the ability to carry out this responsibility. Defining the appropriate use of home health services more clearly could help constrain home health spending while allowing the Medicare program to continue to meet the needs of its beneficiaries.

Prospective Payment

The Commission believes that the current cost-based payment per visit method should be replaced by a prospective payment system. Prospective payment could slow the growth in home health expenditures and encourage providers to deliver services in a more efficient manner. To be effective, however, the payment must cover more than an individual visit. Ideally, the program should pay for all services furnished over a period of time. Defining this period is difficult, however, because in the home setting it is hard to identify when an appropriate period of treatment begins and ends. In turn, this is complicated because of the lack of a clear definition of the home health benefit, or of the nature of the home health visit.

An additional difficulty in implementing prospective payment is the lack of an adequate case-mix classification system. Such a system is needed to account for variations in patients' needs. Payments should be higher for patients with greater

resource needs and lower for those who require less care. The ability to adjust prospective payment rates for differences in case mix is critical to ensuring fair payment to providers and access to services for patients. Without an adequate case-mix adjustment, prospective payment could unduly reward providers that treat low-cost individuals and penalize those that treat patients with more complex needs.

Developing a case-mix system is a challenging task generally, but it is especially difficult in the home health arena where patients' service needs often depend on multiple factors. For example, functional status and social support needs may be more important than diagnosis in predicting resource requirements for home health patients.

We understand that HCFA is in the preliminary stages of developing a new case-mix system. This system, however, will not be ready for several years. In the meantime, the Commission believes that an interim system should be implemented immediately to stem rising expenditure growth. I would like to discuss several of the Commission's views on such a system.

An Interim Payment System

An interim payment system should specify per visit payments and limit total home health payments for beneficiaries. For the short term, per visit payments could continue to be based on the current method of agency-specific costs subject to a per visit limit. This method can effectively constrain per visit payments, although it continues the link between costs and payments, contrary to the premise of prospective payment. Alternatively, establishing prospective per visit payment rates could begin the transition away from cost-based payments. Separate rates for each home health service could be calculated using agency-specific costs, national average amounts, or a blend of the two. Either method would reward facilities for keeping their costs per visit below the payment amount.

As I mentioned earlier, however, a home health visit is not uniformly defined. Therefore, agencies could simultaneously reduce their costs and increase revenues by shortening visits and providing more of them. I should note that the Commission also recommends that Medicare require consistent home health visit coding. This would permit home health usage to be monitored and evaluated over time. This information also is necessary to develop an effective case-mix adjustment system.

Beneficiary payment limits would dampen the incentive to provide more visits because such limits would encourage home health agencies to control the number of visits and adjust the mix of services furnished to each user. The limits could be associated with payments for services provided over a specific period, such as a year or a month. An annual limit would constrain use for those beneficiaries who use services for a long period of time. Given that most visits are associated with these users, this might be an appropriate course of action. Shorter time periods would affect service use for almost all Medicare patients, although agencies could respond by spreading visits over a longer period to reduce the likelihood that payments for a beneficiary would reach the limit in the given time frame.

Beneficiary limits could be calculated based on agency-specific costs, national average expenditures, or a blended amount. The limits could be applied to an agency's aggregate payments or to spending for individual patients. Regardless of the method chosen, an outlier payment mechanism similar to that under Medicare's Prospective Payment System for acute care hospitals could be incorporated to minimize incentives to avoid high-cost cases.

Home Health Copayments

Mr. Chairman, with the exception of lab services, home health is the only Medicare benefit not subject to beneficiary cost-sharing. The Commission believes it is both

appropriate and fair to impose modest copayments, subject to annual limits, for home health care visits.

With copayments, patients would share financial responsibility for services with the program. Although many beneficiaries have some form of supplemental insurance or Medicaid coverage that could cover these outlays, copayments could curb use by involving beneficiaries more in treatment decisions and making them more aware of service costs. Copayments also might limit fraudulent billing practices, since beneficiaries could identify services for which Medicare was billed but that were not delivered.

Conclusion

Payments for home health care services are growing out of proportion compared to the rest of the program. The Commission believes its recommendations to reform coverage and payment policies are necessary to constrain spending while ensuring quality care for Medicare beneficiaries.

This completes my formal testimony, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.